Raveedha Care Limited

Eastcotts Care Home with Nursing

Inspection report

Eastcotts Farm Cottage
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 22 February 2017 and was unannounced. Eastcotts Nursing Home provides care and accommodation for up to 59 older people. There were 48 people living at the service on the day of our inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in January 2016 and rated the service as requires improvement. At this inspection we found that some improvements had been made. However we continued to have concerns about staff deployment and management of clinical risks. The rating therefore remains as requires improvement.

People spoke positively about the service and the care that was provided. They told us that the staff were kind and caring. There were sufficient staff, however they were not always deployed effectively and this placed people at risk of poor care. Risks were identified but not always managed effectively. For example, people at risk of pressure ulcers were identified and provided with specialist mattresses but we found that some of these were set at the wrong setting for people, which meant that they did not work effectively to prevent people from acquiring a pressure ulcer. Peoples health needs were not always well managed and staff were not always following best practice, for example in how they managed and documented the support provided to people with wounds and catheters. This could lead to confusion as to what care had or had not been provided and failed to mitigate the risks to people's welfare and poor care.

People were given their medicines as prescribed but they were not always stored securely. The checks on clinical equipment were not sufficient and as a result may not work effectively.

The systems in place to recruit staff were thorough and references and other checks were undertaken before staff started work at the service. Staff had a good understanding of abuse and the steps that they should take to protect people. A training programme was in place to ensure staff had the skills and knowledge to undertaken their role. There were however still some gaps and we found that staff had a limited understanding of the Mental Capacity Act 2005 (MCA).

Staff told us that they were well supported when they started work at the service and told us that they received regular supervision.

People enjoyed the meals provided and supported to eat well.

Care plans were in place and staff had a good understanding of people's needs. Activities were provided

which promoted peoples wellbeing and we were told that these were being extended to weekends

The manager was approachable and promoted an open culture. Complaints were taken seriously and investigated. People's views were sought in a variety of ways including resident meetings and questionnaires. The provider had invested in the fabric of the building and there was a new lounge in use for people to use. There were systems in place to drive improvement but these would benefit from being more robust to ensure consistency of practice.

During this inspection we identified a breach of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Risks were identified but not always managed effectively.

Medicines were not safely stored and this presented risks to people. However we found that medicines were administered as prescribed.

There were sufficient numbers of staff to provide care to the people who lived at the service however staff could be deployed more effectively to keep people safe.

The staff had received training in protecting vulnerable adults and were aware of how to report safeguarding concerns they might have.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent and the Mental Capacity Act was not consistently well understood by staff.

People were supported to maintain their health by visiting professionals such as chiropodists, dentists and GP's. However clinical procedures regarding the management of wounds and catheters was not sufficiently clear.

People were supported to maintain a balanced diet.

Staff received ongoing training and support.

Is the service caring?

Good

The service was caring.

Staff were kind and attentive to people.

People were involved in making decisions about their care and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs and preferences were outlined in a care plan which was subject to regular review.

Activities were available for people to access which promoted their wellbeing

People told us that they were confident that concerns would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Relatives, peoples living in the service and staff expressed confidence in the management of the service.

Improvements had been made since the last inspection but there continued to be shortfalls which had not been fully addressed.

Audits were undertaken but had not identified some of the shortfalls we found.

Eastcotts Care Home with Nursing

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 22 February 2017 and it was unannounced. The inspection team consisted of two inspectors, a professional advisor and an Expert–by-Experience. The professional advisor was a registered nurse and focused on clinical care within the service. An expert by experience is a person who has personal experience of care services and caring for an older person

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

There were 48 people living in the service and we spoke with nine people and three relatives. We spoke with ten staff, the manager, deputy manager an independent auditor. We looked at three staff records; eight peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration. Following the inspection we gave feedback to the manager and the provider.

Requires Improvement

Is the service safe?

Our findings

People told us that their experience of care at the service was positive however we found the systems to manage risks and keep people safe did not always work effectively. One person told us "Yes, I do really feel safe here, it's nice". A relative told us, "I think it's nice and safe here. The home did have bad name a few years back, but it's now improved a lot. I come most days…... I never see a problem here."

The systems in place for the oversight of equipment and management of risk were not fully effective. Waterlow risk assessments were undertaken to identify those at risk of pressure damage. Where risks were identified, specialist mattresses were in place to reduce the likelihood of injury. However we found that a number of the mattresses settings were incorrect and meant that the mattress was not working effectively. There was no guidance or information in the care plan concerning the correct setting of the mattress for people's weight. It is vital to ensure the mattress is set correctly to obtain the most effective pressure relief. For two of the people whose care we looked at the person weighted considerably more than the mattress setting. This meant that when the mattress inflates, the cell did not have enough air in it to support the person off of the solid bed base, therefore offering ineffective pressure relief.

Equipment was not being checked or maintained to ensure that it was safe to use. We looked at a range of clinical equipment, such as syringe drivers, suction machine, blood pressure recording equipment and blood glucose monitors. We found that some of the equipment was out of date. Equipment should be checked on a regular basis to ensure that it is clean, well-stocked, in date and ready to use, as the need arises. The Provider subsequently informed us that these items were checked as part of portable appliance testing.

Assessments of peoples moving and handling needs were undertaken but the care planning documentation did not always record the size or type of sling which was suitable for individuals. We spoke to the manger about this and they told us that that they had a separate list and a copy of this was subsequently forwarded to us. We noted some confusion about which sling should be used to assist one individual, as their normal sling was in the laundry. Staff used a toileting sling which did not give the individual who had body rigidly associated with his health condition proper support; this could mean that a person could fall out of the sling when raised in the air.
It was agreed with the manager that the sling size and the procedures for staff to follow should be clearly documented.

Documentation regarding areas such as catheter care and wound care were not sufficiently clear. This meant that people may not receive the care that they needed. For example we looked at the plan of care for one individual who had an indwelling catheter but found that the management of the leg bag was not documented. Nursing staff told us that that this was undertaken weekly and the bag was dated, however when we checked there was no date written on the bag and we could not be confident that this was changed as planned. Leg bags should be changed weekly as the non-return valve that prevents urine flowing back up the catheter can deteriorate, if the bag then becomes full, urine can be pushed back up the tubing into the bladder, this will cause discomfort and a high risk of urine infection. We looked at the care of

another individual and noted that there was an anomaly in the size of catheter, as it was smaller than what was being used than previously. There was no specific care plan and we could not see the rationale for this decision as none was documented and we asked the nurse on duty to follow up. Documentation should provide staff with clear information on the size, frequency of catheter changes and the correct management of the leg bags, to ensure staff maintain an effective, sterile drainage system and lessen the risk of urine infections.

Similarly with wound care the documentation were not up to date or consistently clear. For example they did not specify the type of dressing to be used or the frequency of dressing changes. We found that different dressings had been used but the rationale for doing so was not clear. The provider subsequently told us that they had used a different brand as they did not want to leave the old dressing on for too long. We were told that staff made diary entries when dressing were due but we found this hard to follow. We expressed our concerns to the manager who showed us a redrafted wound care plan but further work is needed to ensure people's needs are consistently met.

Environmental risks were better managed and we saw that checks were being undertaken on a range of equipment such as, water temperatures and hoists to ensure that they were safe. Checks on fire equipment were undertaken to make sure they could be used in an emergency and regular fire drills were being undertaken. We did note however that a number of doors were propped open which meant that they would not close in the event of a fire. Some of the call bells were not working effectively on the day of our visit and we have recommended that the provider seeks advice about these emergency systems from a reputable source.

People were supported to take their medicines but practice did not always follow the recommended professional guidance regarding storage. The medicine trolley was kept locked when unattended however we found that the fridge containing medication was unlocked and accessible to people using the service and visitors. We asked a member of staff about the door, they told us "I don't know the code, it isn't usually locked." This was not good practice and places people at risk of harm.

The shortfalls in the management of risk associated with people's needs and the storage of medication are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The nurse was observed supporting people with their medicines and gave people the time they needed and ensured they had a drink. People told us that they received their medication as prescribed, One person told us, "They put on my creams….and I get tablets at night time. I can have medication for pain when I need it."

We observed that the nurse signed the medication administration charts after the medicines had been taken. We checked samples of medicines and Controlled Drugs (CD) and saw that they were appropriately signed for and the quantities in stock tallied. We looked at the medication administration records for an individual who had diabetes. We saw that there was a protocol for staff to follow when administering insulin which set out how much should be given and we saw that this staff referred to this prior to administering. Photographs were in place for identification purpose. Temperature checks for the room and fridge were recorded daily and were within an appropriate range. Body maps were not in place to show where on the body patches were placed. These ensure that staff place the patch on alternate sites at each administration. The provider told us that the location of the patches were recorded on the MAR.

We saw that the service used dependency scoring to ensure that people's needs and staffing levels corresponded. Our observations were that there were sufficient staff on duty on the day of our visit; staff were available and responded to call bells promptly. Staff told us that there were generally sufficient staff

and agency staff were used to cover shortfalls although there were sometimes problems when staff went off sick at short notice. There was some demarcation of role and some nursing staff primarily saw their role as dealing with medication. One member of staff told us, "The nurses never help with care, I think that care should come before any paperwork."

We noted that staff breaks were not always well managed and there were periods when there were less staff available. Most care and nursing staff worked long days and this meant they had a break in the middle of the day and this impacted on care delivery. For example we spent some time in two of the lounges in the early afternoon. One member of staff supported people to the toilet but this meant that there were significant periods when people were left unattended. There was one individual who was at high risks of falls and this individual repeatedly tried to get up and walk across the room. We had to intervene to support this person and expressed our concerns about staff visibility to the member of staff on duty. At the same time in another lounge, we also observed that there were no staff present and saw a person tapping their chest. They told us "I've got trouble with my breathing." We immediately called a staff member who went off an inhaler, and after some minutes they settled down after using it. We recommend that staffing should be organised to ensure that there are sufficient staff available to consistently meet people's needs.

Staff recruitment processes were in place and these helped to ensure suitable staff were employed. We looked at three staff files and found satisfactory checks were in place for staff, this included written references and checks from the disclosure and barring service to ensure they had no offences which might made them unsuitable to work in care. Interviews assessed appropriate competencies and there was evidence within the staff files that relevant checks with professional bodies were made for qualified nursing staff.

People were protected from harm as staff were aware of their responsibilities and told us that they were encouraged to raise matters of concern. Staff told us that they had received training in safeguarding vulnerable people. One member of staff told us, "I would have confidence in the manager"

Requires Improvement

Is the service effective?

Our findings

People told us that staff supported them very well with their healthcare needs. However we found shortfalls in the clinical oversight. We observed and saw records which demonstrated that staff worked in conjunction with other healthcare professionals such as GPs and the speech and language service. A visiting GP spoke positively about the service and care provided. We observed that staff were alert to changes in peoples wellbeing and were proactive in accessing additional health care support. For example we saw that the nurse had noted that one individuals decreased flood and fluid intake and we saw that they had arranged for them to see the GP. However some of the care planning documentation used to guide staff in the planning for the needs of people in relation to the care of their catheter and pressure care did not mitigate the risks to their health, welfare and safety.

Staff told us they had received training appropriate to their role for example nursing staff told us that they were supported with their revalidation One of the nurses on duty told us, " I can go on the training they have here, so I keep up to date and my revalidation is nearly complete now ". Care staff told us that that they had undertaken training such as in moving people and infection control. One member of staff told us for moving and handling training, "We get to go in the hoist" so we know what it like for the people we support. There was a training matrix in place which set out what training staff had completed and identified those individuals who needed refresher training. We saw that there were some gaps on the training matrix but the manager told us that further training was planned on areas such as, mental capacity act and end of life care. We saw that staff had been appointed as champions in areas such as dignity and end of life care, their role was to promote good practice and support staff

The manager told us that newly appointed staff undertake the care certificate, which is a national initiative to ensure that newly appointed staff are properly inducted into their role. Mentors are also allocated to new staff at the beginning of their training to support them.

We saw that observations of practice were undertaken which explored how staff were providing care and ensure they were demonstrating what they had learnt at training. Staff commented that they felt well supported and received regular supervision. The manager told us that 75% of staff had received an appraisal and further were planned.

The Mental Capacity Act was an area where there were some training gaps and we found that this area was not well understood. For example we noted that there were a significant number of people in bed, some of whom had limited capacity and it was not clear what the rationale for this was and whether spending significant periods in bed was in their best interests. The provider subsequently told us that this was documented in their care plan. We also saw that there was a plan to crush and give medication in a covert way to an individual. While there was a letter from a GP we could not see evidence that a full consultation had taken place to evidence that their best interests had been fully considered. Some relatives had signed consent documentation and it was not clear if they had power of attorney and able to do so.

We saw that a number of people had decisions they had made recorded such as Do Not Attempt Cardio

Pulmonary Resuscitation (DNACPR) orders in place which set out their wishes not to be resuscitated in the event of a cardiac arrest. These were maintained in people's care records and highlighted so they could be easily accessed in an emergency. A small number of applications had been made to the appropriate professionals for assessment when people who lacked capacity and needed constant supervision to keep them safe as required by the Deprivation of Liberty Safeguards (DOLS.

People told us that they enjoyed the food and we observed staff supporting and encouraging people in a patient manner. People could choose where they ate their meals, a majority of people sat at dining tables in the main dining area but other people chose to eat in their rooms. People were shown the meals and enabled to make a choice about what they wanted to eat. Finger foods were provided to some individuals so they were able to eat independently, others were provided with assistive products such as plate guards. Condiments and drinks were available on the tables and staff were proactive in offering these to people. The cook told us that told us that they sourced all her food locally, and it was all cooked on the premises. The menu was adjusted to take account of people's needs and the introduction of finger food and this was working well.

We observed that one person ate only a little of the food on their plate before they stopped eating, we saw a member of staff gently encouraging them to eat and they started to eat again. This happened on several occasions throughout the meal and at one point the member of staff began singing to the individual as they gently encouraged them to eat a little more. Another individual refused their meal but we observed the member of staff trying to tempt the individual with different meals and options. We observed that this information was handed over to the nurse on duty

We saw that there was a list in the kitchen which identified people's preferences and those with allergies and requiring specialist diets, such as diabetics.

We saw that people were regularly weighed however the information was not well organised and it was difficult to identify who had lost or gained weight and correspondingly how often they should be weighed. One person for example had lost weight but we could not see records to indicate that this had been identified and acted on. Following the inspection the provider forwarded additional documentation which was clearer however there was no indication if the resident was to be weighed on the hoist or the sitting scales. This is important as the weight obtained can vary if taken on different scales.

Good

Is the service caring?

Our findings

People told us that staff were kind and attentive and they felt cared for. One person told us, "I was always terrified of going into a home, terrified of the smell, but you never get that here, the only smell is of cleaning products. They have great staff, I have a good relationship with them…they talk to me." A visitor told us I'm very comfortable with the home. I think the food is good, the carers are friendly, very good."

We spent time in the communal areas and observed that the atmosphere was relaxed. We observed staff interacting with people in a person centred way, for example we observed staff sitting with people and their relatives, supporting the conversations and encouraging the person to talk about what they have been doing. The relatives appreciated the time the staff spent talking to them and their relative together.

Staff treated people in a respectful way. We saw that one person top had moved up their body exposing their midriff, the staff member noticed this and immediately pulled the top down, protecting the individual's dignity. Staff were kind and patient, they gave people the time they needed to communicate and listened to their responses with interest. When supporting people to eat, staff sat alongside them and supported them in an unrushed way.

The majority of the staff had worked at the service for some time and were knowledgeable about people's needs. They spoke about people and their work in a positive way and had good relationship with those they supported. We observed people responding to people in a warm way for example smiling when staff approached One member of staff who worked at the service as a bank member of staff said, "I like it here it is very caring."

People told us that they were involved in making decisions about their care and had a say in how it was provided. We observed people being offered choices and saw examples of where people's independence was promoted. We observed staff supporting an individual who decided to return to their bedroom after lunch. Staff were attentive and provided reassurance to the individual as they started to mobilise. They gave the person the space they needed to propel themselves up from their chair and move independently

We saw that the provider sent out questionnaires to people who used the service, relative and staff about their experience of the care provided. We saw that one person had responded," Any issues are always resolved amicably with staff, I believe that staff are always willing to listened to any issues I raise, and I am not slow to raise my concerns." Specific questionnaires on specific areas such as meals were also undertaken. We saw that meetings were held with relatives on a quarterly basis. The minutes of the recent meetings were provided and demonstrated that people were encouraged to share their views and opinions.

Good

Is the service responsive?

Our findings

People told us that they were happy with the care, one person said, "They all look after me very well here. I'm very comfortable with everything". A relative told us their relative had been assessed as being at the end of life when they had arrived at the service but they spoke highly of the care and said the staff had made a difference and, "Turned round our relative"

There were care plans in place and the service was in the process of introducing a one page profile which was an introduction to the persons needs enabling any staff member to know enough about the person to meet their needs in a safe way. The care plans then provided more in-depth information about their needs, risks associated with care and how these should be monitored and addressed. Information was not always easy to find and we noted that there were a number of different records in place which led to some duplication and could mean that key information is missed. There were also some gaps in the recording for example around what continence products people required but we were assured by the manager that the care plans were a work in progress and they were being developed and streamlined to ensure that staff could find information they needed quickly.

We found that the majority of the staff had worked at the service for some time and were knowledgeable about people's needs, although they told us that they did not always get time to read the care plan. However there were regular handovers which updated them on changes to people's needs. The service uses the resident of the day scheme to review people's needs and ensure that they were current and we saw evidence which demonstrated that people and their relatives had been consulted and the plans had been updated.

People were supported to follow interests which promoted their wellbeing. All the people we spoke with commended the activity provision and praised the activities staff. We saw that there were two staff in post and were told that the provision was being extended into the weekends.

The activities co-ordinator told us that the purpose of their role was to, 'ensure that every person has the best possible day.' We observed this in practice during interactions between the activity coordinators and people using the service. The activities team spoke with passion about the input they have within the service, they provide both group and one to one activities either in the communal areas and in people's bedrooms as required. We saw that people who spend most of their time in their rooms had regular one to one activity sessions with the activity coordinators who had spent significant time understanding what people respond to well and wish to spend their time doing. We were told that the Provider had invested in the activities team as they understood the importance of people enjoying their time in residential care services and the activities co-ordinator managed the additional funding carefully to ensure people got the most out of new equipment, funding for outings and resources. The activities team felt that they had the 'buy-in' from all of the staff team to their pledge of ensuring people have the best possible day. One of the people we spoke to told us, "The only thing I miss is a pub, the nearest pub is 2 miles away, be nice to go there more often." However we saw that during lunch a carer asked the person whether they "would like one of the beers", which the individual said he would, and the carer came back with a bottle that she opened

and poured out for him. The person looked happy and relaxed.

We observed that there was a range of sensory equipment in place which provided comfort to people including items to touch and hold. A relative told us that my relative "Loves this new sensory light they have given to them. [My relative] eyes come alive and he looks at all the lights and he follows them across the ceiling".

During the afternoon we observed staff managing a game of card bingo with a small group of people. The member of staff managed the session well, and had time for each person making sure that people could fully participate and knew what the cards were.

The service had a robust complaints procedure which was managed well. People we spoke to knew that they could make a complaint if they wished and knew how to do this. Relatives told us that they knew the manager well and that she was always available to discuss any minor concerns if they had any. The manager told us that "No complaint is too small" and all concerns were taken seriously. We reviewed the complaints process and saw that there were very few complaints, but those which were there had been logged, responded to and action had been taken as appropriate.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place who was a registered nurse, and known to people living in the service and relatives. We were told by staff and people living in the service that they were visible. One person told us "[The manager] is lovely – I see her around the home a lot."

The manager was enthusiastic about their role and spoke passionately about delivering good quality care. They told us that everyone is encouraged to participate in improving the service and we saw that they had an open door policy and encouraged feedback ensuring a culture of openness. At the last inspection we rated this service as requiring improvement and while we found that improvements had been made in key areas such as activities and dementia care, further work was needed. Some of the shortfalls we identified at this inspection related to shift leadership and the role of nursing staff. We also identified some clinical issues such as pressure care, medication and the oversight of clinical equipment

The manager was aware of their responsibilities under the duty of Candour and the need to be open when things have gone wrong. The manager told that there had been a recent incident which had occurred which was in the process of being investigated but they had identified that there was learning needed in how they support people who were independent with personal care, They told us that as a result they had started to make some changes and we saw that there had been discussions on what had happened at staff meetings about what should have happened.

The manager was supported by a deputy manager who was also the clinical lead
however when looked at the rota we saw that they were only working on a supernumerary basis for one shift weekly which meant that they had only limited time to implement change at the service. We expressed our concerns to the provider and they agreed to review this.

Morale at the service was good and staff told us that the manager was approachable and supportive. One member of staff told us, "[The manager] is really good and listens to us, so we all work together ". Another member of staff said "[The manager] is very good, you can go and talk to her anytime." Staff told us that there were daily handovers and regular staff meeting were held. One member of staff told us, "But we all chat together all the time about anything, it's a nice group of staff here – I've been here for 6 years and have seen the improvement in the home".

The manager had completed home life which was run by the Local Authority and put managers of different homes in touch with each other to discuss and share good practice. The manager spoke positively about their experience of the home life project and clearly benefited from discussions on best practice and new initiatives. We saw that the manager had put a number of initiatives into place such as the appointment of dignity champions to drive change at the service. The service also had an awards scheme in progress, to reward staff for going the extra mile; staff were chosen through nominations from staff relatives and people in the service.

We saw that the provider had recently invested in upgrading and refurbishment at the service, for example a

new lounge had recently opened which was bright and airy and provided an additional space for people to move around. There was a new bathroom and toilets which were nearing completion.

Audits had been undertaken to monitor the care delivery and identify any shortfalls, however they would benefit from being more robust. We saw that audits had been undertaken on a range of areas including on infection control and medication. However we could not see any system in place to monitor areas such as bathing and the audits had not identified some of the issues we identified around medication and pressure care. Observations on practice were undertaken to ensure that staff were working to the required standards. The provider visited the service on a regular basis and we saw that the provider had organised for a consultant to visit the home and support the manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to individuals were not being effectively managed